Patient Information

Today's Date: _____

Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name? _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Street Address: _____ City/State/Zip: _____

Phone: Cell _____ Home _____ Work _____

Email: _____ (We use email for appointment communications. ZERO SPAM)

Preferred method of contact (check all that apply): ☐ Phone Call ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Widowed ☐ Minor

Emergency Contact: _____ Relationship: _____ Phone #: _____

Please list other family members who are patients of record: _____

Occupation: _____ ☐ Retired ☐ None ☐ Student School: _____

How did you hear about us? ☐ Web Search ☐ Driving down Del Prado ☐ Social Media ☐ Advertisement ☐ Community Event

Referred by another patient : _____ ☐ Friend ☐ Relative ☐ Doctor Referral

Responsible Party Information ☐ Same as above, I am the responsible party for my account

☐ Spouse ☐ Father ☐ Mother ☐ Guardian

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____ SSN: _____ Sex : ☐ Male ☐ Female

Street Address: _____ City/State/Zip: _____

Phone Number: Cell _____ Home _____ Work _____

Primary Dental Insurance Information ☐ I do not have dental insurance

Name of Policy Holder: _____ DOB: _____ SSN: _____

Employer: _____ Insurance Company: _____

Insurance Company Phone #: _____ Group #: _____ Member ID: _____

Secondary Dental Insurance Information

Name of Policy Holder: _____ DOB:_____ SSN: _____

Employer: _____ Insurance Company: _____

Insurance Company Phone #: _____ Group #: _____ Member ID: _____

Sharing of Health and Payment Information ☐ Do not release my health information to anyone (not even family)

Cape Dental Care may disclose details of my health information and billing information to my personal representative(s) listed below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient/Guardian Signature: X _____ Date: _____

Health History

Dental/Surgical:Risk: _____
(official use only)

Patient Name: _____ Today's Date: _____

Physician Name: _____ Physician Phone #(or city): _____ Year of Last Medical Exam: _____

Have you had any serious Illnesses, operations, or hospitalizations in the last 5 years? Yes ☐ No ☐ If yes, explain below:

Do you have any ALLERGIES or SENSITIVIES? Penicillin ☐ Local Anesthetics ☐ Codeine or Narcotics ☐ Latex ☐ Acrylic ☐
Certain Metals ☐ Environmental ☐ None ☐ Other(s): _____

	Yes	No		Yes	No		Yes	No
Heart Attack Date: _____	☐	☐	Asthma _____	☐	☐	Liver Disease _____	☐	☐
Chest Pain/Angina _____	☐	☐	COPD _____	☐	☐	Hepatitis A, B, or C _____	☐	☐
Cardiac Stent(s) Date: _____	☐	☐	Chronic Cough _____	☐	☐	Kidney Disease _____	☐	☐
Pacemaker/Defibrillator _____	☐	☐	Tuberculosis _____	☐	☐	Diabetes - Recent A1C? _____	☐	☐
Heart Surgery Date: _____	☐	☐	Stroke _____	☐	☐	Cancer - Type: _____	☐	☐
Artificial Heart Valve _____	☐	☐	Seizures _____	☐	☐	Radiation or Chemo Tx _____	☐	☐
Irregular Heartbeat _____	☐	☐	Headaches/Migraines _____	☐	☐	Chronic Fatigue _____	☐	☐
Atrial Fibrillation _____	☐	☐	Depression _____	☐	☐	Sleep Apnea - CPAP? _____	☐	☐
High Blood Pressure _____	☐	☐	Anxiety _____	☐	☐	Acid Reflux/GERD _____	☐	☐
Low Blood Pressure _____	☐	☐	Thyroid Issue _____	☐	☐	Digestive Problems _____	☐	☐
Blood Thinners _____	☐	☐	Autoimmune Disease _____	☐	☐	Neck or Spinal Problems _____	☐	☐
Bleeding or Clotting Disorders __	☐	☐	HIV or AIDS _____	☐	☐	Artificial Joint _____	☐	☐
Poor circulation _____	☐	☐	Cold Sores/Fever Blisters _____	☐	☐	Arthritis _____	☐	☐

	Yes	No			
Tobacco Use?	☐	☐	Smoke ☐	Chew/Dip ☐	Vape ☐
Alcohol Use?	☐	☐	Daily ☐	Weekly ☐	Monthly ☐
Drug abuse? (Or previous history)	☐	☐	Alcohol ☐	Rx Meds ☐	Illicit Drugs ☐

Please specify: _____

For Women
Are you pregnant or nursing? Yes ☐ No ☐ Due Date: _____

Osteoporosis or Osteopenia? Yes ☐ No ☐
Have you taken **Bisphosphonate Medications?** Yes ☐ No ☐
(Boniva, Prolia, Fosamax, Actonel, Reclast, Zometa) # of Years? _____

Is there **anything else** important for us to know about your health?

	Medication or Supplement	Purpose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

If more than 9, please bring medication list to your appointment

Pharmacy: _____ Location (street): _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes to my health status, or if my medicines change, I shall inform the dentist and staff at the next appointment .

PATIENT SIGNATURE : (If your software doesn't support eSignatures, you can sign at the office after we print the form)
(Parent or Guardian) **X** _____ **DATE:** _____

Reviewed By Dr. _____ Date: _____ Blood Pressure: _____ Pulse: _____ ASA: _____

Dr. Notes:

Medical Updates: I have read my PREVIOUS MEDICAL HISTORY and confirm that adequately states past and present conditions.

Date	Update	Patient Initials	Reviewed By

Dental History

Today's Date: _____

Previous Dentist

☐ No previous dentist

Name of Previous Dentist: _____ City: _____ Year of Last Visit: _____

Year of last full set of X-rays: _____ ☐ Not sure I routinely visit every: ☐ 3 mo ☐ 4 mo ☐ 6 mo ☐ 12 mo ☐ Not routinely

☐ I would like to have my previous records and X-rays forwarded to Cape Dental Care. (There is a separate Records Release form to fill out.)

Personal History

Are you fearful or anxious about dental visits? ☐ Yes ☐ No ☐ Slightly Rate on a scale of 1 (not fearful) to 10 (very fearful):_____

Have you had any negative dental experiences? ☐ Yes ☐ No If yes, explain: _____

Do you have a family history of dental problems? ☐ Yes ☐ No If yes, explain: _____

Do you have a specific dental problem? Describe: _____

Gums

Do your gums bleed or hurt when you brush or floss? ☐ Yes ☐ No Do you have gum recession? ☐ Yes ☐ No

Has a dentist ever diagnosed you with gum disease? ☐ Yes ☐ No Do you pack food between your teeth? ☐ Yes ☐ No

Do you have a foul odor in your mouth (halitosis)? ☐ Yes ☐ No

Teeth

Have you had any of the following? ☐ Missing Teeth ☐ Cavities in the last 5 years ☐ Toothache ☐ Sensitivity to Cold or Sweets

☐ Broken Tooth ☐ Pain when chewing ☐ Dry Mouth ☐ Loose Teeth

Bite and Function

Did you ever have braces or orthodontic treatment? ☐ Yes ☐ No Does your bite feel good and stable? ☐ Yes ☐ No

Can you eat an apple without any difficulty? ☐ Yes ☐ No Do your jaw joints every bother you? ☐ Yes ☐ No

Do you clench or grind your teeth at night? ☐ Yes ☐ No Do you have any head or neck pain? ☐ Yes ☐ No

Esthetics

Do you like your smile? ☐ Yes ☐ No What don't you like? _____

Are you interested in having whiter teeth? ☐ Yes ☐ No Have you ever whitened or bleached your teeth before? ☐ Yes ☐ No

Have you ever been disappointed in the appearance of previous dental work? ☐ Yes ☐ No _____

Are you interested in Invisalign or orthodontics? ☐ Yes ☐ No Are you interested in Veneers or Crowns? ☐ Yes ☐ No

Diagnostic Records and Photo Consent

I hereby authorize Cape Dental Care to take photos, 3D imaging, and videos ("Images") of my teeth and face. These images will be used for diagnostic treatment planning and communication with our treatment team. These images may also be used for 1.) Educational purposes including study club meetings, lectures, and professional publications, and 2.) Promotional materials to show patients of record, or out of the office in any form of advertising for the practice, including but not limited to our website and our social media accounts.

☐ I agree to the use of my images as described above

☐ I only agree to have my teeth shown without any identifying facial features

☐ I decline (use only for diagnostic purposes)

Patient/Guardian Signature: _____

Dr. Notes:

Office Policies and Consents

Today's Date: _____

Fees and Payments

We pride ourselves on having the highest quality dental care available, but with reasonable prices.

Payment is due at the time of service: We accept cash, major credit cards, checks, and third-party lenders (CareCredit and Proceed Finance). Any balance left on an account over 60 days will be subject to a 1.5% per month interest charge.

Personal Checks: No international, third-party, or postdated checks will be accepted. We may process checks by Remote Image Deposit the same day as the visit. There are fees associated with returned checks ("bounced checks"), which are set by your state.

Payment Plans (Financing with a third-party): Cape Dental Care is not responsible for the financial agreement between you and third-party lenders. **CareCredit** and **Proceed Finance** are each subject to their own credit approval. CareCredit is more popular for $5000 or less. Proceed Financing will lend up to $60,000. Please review each financial agreement carefully, as you will be solely responsible for the terms.

Refunds: All sales are final. Dental products are not returnable.

Patient/Guardian Signature: X _____

Insurance

We have a dedicated insurance coordinator to help you with understanding your plan.

1. We are not contracted with your insurance company. As a courtesy, we will file your insurance claim, but only if your plan allows for **OUT-OF-NETWORK** benefits. Your insurance company will not pay for your treatment if you are required to see an in-network dentist (ie. HMO).
2. You are responsible for all of our fees, regardless of insurance coverage. We will do our best to **ESTIMATE** what your insurance company will pay for based on what information your insurance tells us. But this is not a guarantee of payment. **The full responsibility is on the patient to understand their specific policy, yearly maximums, waiting periods, and limitations of the policy.** We recommend any treatment over $300 to be pre-authorized by the insurance company. This usually takes between 2-4 weeks.
3. Insurance companies pay based on their own "Reasonable and Customary" fee schedules, which may result in less payment than expected. The patient is required to pay co-pays and deductibles at the time of service.

I hereby authorize for the release of information necessary to process my claim. I hereby authorize payment of all benefits directly to Cape Dental Care, that are otherwise payable to me. I acknowledge and understand that I will be fully responsible for any balances on this account not covered by my insurance.

Patient/Guardian Signature: X _____

Cancellation Policy

We will always respect your time and strive to schedule appointments that accommodate your needs.

Please make every effort to keep your reserved dental appointments. **There is a $50 fee for appointments missed or cancelled with less than 48 hours notice.** We understand that emergencies and personal situations do arise and will take this into consideration. We attempt to confirm all appointments through telephone, text, and/or emails. Please respond promptly to our attempts to reach you regarding your dental appointments.

Patient/Guardian Signature: X _____

Electronic Communications

We would like to communicate with you using **phone, email, and texting**. These platforms have some level of risk and third parties may be able to intercept and read our communications. For all sensitive communications we will either call or send secured, encrypted emails.

I consent to communication via: ☐ Text ☐ Email ☐ Phone

☐ I only wish to be called on my phone

Patient/Guardian Signature: X _____

Receipt of Notice of Privacy Practices

I hereby acknowledge that a copy of Cape Dental Care's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Patient/Guardian Signature: X _____